

# Disaster-related Mortality Surveillance Form .Complete one form per decedent

**Complete the form for all known deaths related to a disaster:** This information should be obtained from a medical examiner, coroner, hospital, funeral home or DMORT (Disaster Mortuary Team) office. Please, complete one form per decedent.

Form v1.1  
Rev.03/21/2007

Part I General information			
<b>1.Type of disaster:</b> <input type="checkbox"/> Hurricane (name _____) <input type="checkbox"/> Heat wave <input type="checkbox"/> Tornado <input type="checkbox"/> Technological disaster <input type="checkbox"/> Flood <input type="checkbox"/> Terrorism <input type="checkbox"/> Earthquake <input type="checkbox"/> Other (specify) _____		<b>2. Facility type (info source):</b> Please check one that best applies. <input type="checkbox"/> ME office <input type="checkbox"/> Funeral home <input type="checkbox"/> Nursing home <input type="checkbox"/> Coroner office <input type="checkbox"/> Hospital <input type="checkbox"/> DMORT office <input type="checkbox"/> Other (specify) _____	
<b>3. Facility address:</b> Street _____ County/parish _____ State _____ Z-code _____		<b>4. Contact person (informant):</b> Name _____ Phone number _____ Email Address _____	
Part II Deceased information			
<b>5. Case / medical record number:</b> _____		<b>6. Body identified?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending	
<b>7. Date of Birth (MM/DD/YY)</b> ____/____/____ <input type="checkbox"/> Unknown		<b>8. Age in years:</b> ____ <input type="checkbox"/> < 1 yr <input type="checkbox"/> Unknown	
<b>9. Residential address of decedent:</b> County/parish _____ City _____ State _____ Zip code _____		<b>10. Ethnicity:</b> <input type="checkbox"/> Hispanic <input type="checkbox"/> Non Hispanic <input type="checkbox"/> Unknown	
<b>11. Race:</b> <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Other race			
<b>12. Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undetermined	<b>13. Date of Death:</b> (MM/DD/YY) ____/____/____ <input type="checkbox"/> Unknown	<b>14. Time of Death:</b> <input type="checkbox"/> ____ (24 hr clock) <input type="checkbox"/> Unknown	<b>15. Date of body recovery:</b> (MM/DD/YY) ____/____/____ <input type="checkbox"/> Unknown
<b>16. Time of body recovery:</b> <input type="checkbox"/> ____ (24 hr clock) <input type="checkbox"/> Unknown	<b>17. Place of death or body recovery:</b> <input type="checkbox"/> Decedent's home <input type="checkbox"/> Evacuation Center/shelter <input type="checkbox"/> Vehicle <input type="checkbox"/> Hospital <input type="checkbox"/> Hotel /motel <input type="checkbox"/> Nursing Home / long term care facility <input type="checkbox"/> Hospice facility <input type="checkbox"/> Unknown <input type="checkbox"/> Street/Road <input type="checkbox"/> Prison or detention center <input type="checkbox"/> Other (specify) _____		
<b>18. Location of death or body recovery:</b> State _____ county/parish _____ Intersection _____		<b>19. Prior to death, the individual was a:</b> <input type="checkbox"/> Resident <input type="checkbox"/> Non-resident-intrastate <input type="checkbox"/> Unknown <input type="checkbox"/> Foreign <input type="checkbox"/> Non-resident-interstate <input type="checkbox"/> Other _____	
<b>20. Was the individual paid or volunteer worker involved in disaster response?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<b>21. Body recovered by:</b> <input type="checkbox"/> Law enforcement <input type="checkbox"/> Fire department <input type="checkbox"/> DMORT <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> EMS <input type="checkbox"/> Search and rescue <input type="checkbox"/> Family or individual <input type="checkbox"/> Unknown	
Part III Cause and Circumstance of death (check one that best applies)			
<b>22. Mechanism or cause of death— Injury</b> <input type="checkbox"/> Drowning <input type="checkbox"/> Electrocution <input type="checkbox"/> Lightning <input type="checkbox"/> Motor Vehicle occupant/driver <input type="checkbox"/> Pedestrian/bicyclist struck by vehicle <input type="checkbox"/> Structural collapse <input type="checkbox"/> Fall <input type="checkbox"/> Cut/struck by object/tool <input type="checkbox"/> Poisoning/ toxic exposure: <input type="checkbox"/> CO exposure <input type="checkbox"/> Inhalation of other fumes/smoke, dust, gases <input type="checkbox"/> Ingestion of drug or substance <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Suffocation/asphyxia <input type="checkbox"/> Burns (flame or chemical) <input type="checkbox"/> Firearm/gunshot <input type="checkbox"/> Extreme heat (e.g., hyperthermia) <input type="checkbox"/> Extreme cold (e.g., hypothermia) <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown cause of injury		<b>23. Cause of death— Illness</b> <input type="checkbox"/> Neurological disorders <input type="checkbox"/> Meningitis/encephalitis <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Stroke (hemorrhagic or thrombotic) <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Respiratory failure <input type="checkbox"/> COPD <input type="checkbox"/> Pneumonia <input type="checkbox"/> Asthma <input type="checkbox"/> Pulmonary embolism <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Cardiovascular failure <input type="checkbox"/> ASCVD <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Renal failure <input type="checkbox"/> GI and endocrine <input type="checkbox"/> Bleeding <input type="checkbox"/> Hepatic failure <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Diabetes complication <input type="checkbox"/> Sepsis <input type="checkbox"/> Dehydration <input type="checkbox"/> Allergic reaction <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown cause of illness	
		<b>24. Cause of death:</b> <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Pending <input type="checkbox"/> Unknown <b>25. Relationship of cause of death to disaster:</b> <input type="checkbox"/> Direct <input type="checkbox"/> Possible <input type="checkbox"/> Indirect <input type="checkbox"/> Undetermined <b>26. Circumstance of death: (free text)</b> <div style="border: 1px solid black; height: 100px; margin-top: 5px;"></div>	
		<b>27. Manner/intent of death:</b> <input type="checkbox"/> Natural <input type="checkbox"/> Suicide <input type="checkbox"/> Accident <input type="checkbox"/> Pending <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined <b>28. Who signed the death certificate?</b> <input type="checkbox"/> ME/coroner <input type="checkbox"/> Physician <input type="checkbox"/> Not signed <b>29. Date of report completed:</b> (MM/DD/YY) ____/____/____	

# Disaster-related Mortality Surveillance General Instruction for completion of mortality form

<b>General Information</b>	<p><b>Q1. Disaster type</b> — Destructive forces originating from natural environment, such as hurricanes and earthquakes or man made (i.e., terrorist attack, WMD, toxic chemical release, nuclear reactor accident). If it is hurricane, please, specify the name.</p> <p><b>Q2. Facility type</b> — Center involved in dead body handling during disaster and provided the information. Please check one that best applies.</p> <p><b>Q3. Facility's address</b> — Center or agency address at the time of information collection</p> <p><b>Q4. Contact person</b> — Family name/surname or reporting person and phone or email address</p>
<b>Deceased Information</b>	<p><b>Q5. Case/ Medical record number</b> — As appears in facility record</p> <p><b>Q6. Body identified</b> — Yes or No if personal identity (name, DOB or residency) was identified or not</p> <p><b>Q7. Date of birth</b> — Date of birth in MM/DD/YY format</p> <p><b>Q8. Age in years</b> — Age in years, if age is less than one year please check the appropriate box</p> <p><b>Q9. Residential address of deceased</b> — Deceased's home address including county of residence</p> <p><b>Q10. Ethnicity</b> — Hispanic or non-Hispanic category</p> <p><b>Q11. Race:</b> Select one or more of the racial category.</p> <p><b>Q12. Gender</b> — Male, female</p> <p><b>Q13. Date of death</b> — Date of death in MM/DD/YY format</p> <p><b>Q14. Time of death</b> — Enter the exact or estimated time and minute according to 24- hour clock</p> <p><b>Q15. Date of body recovered</b> — Date body taken from place of death in MM/DD/YY format</p> <p><b>Q16. Time of body recovered</b> — Enter the exact or estimated time and minute according to 24- hour clock</p> <p><b>Q17. Place of death</b> — Place where deceased was physically located at the time of death</p> <p><b>Q18. Location of death or body recovery</b> — State and county of death</p> <p><b>Q19. Deceased status prior to death:</b> Deceased residential at the time of death</p> <p><b>Q20.</b> — Refers to work related deaths, this include volunteers deployed for disaster response.</p> <p><b>Q21. Body recovered by</b> — The entity name who recovered the body</p>
<b>Cause and Circumstance of Death</b>	<p><b>Q22. Mechanism or cause of death/ injury:</b> Record the mechanism that best describes the death. Record other and specify if the cause is not listed, but is known.</p> <ul style="list-style-type: none"> <li>▪ <b>Drowning</b> — Includes but not limited to accidental drowning while in natural/flood water or following fall into natural/flood water.</li> <li>▪ <b>Electrocution</b> — Includes but not limited to exposure to electric transmission lines or other unspecified electric current.</li> <li>▪ <b>Lightning</b> — Includes death related to thunder or lightning</li> <li>▪ <b>Motor vehicle occupant/driver</b> — Includes collisions relating to land transport accidents (e.g., car, motorcycle)</li> <li>▪ <b>Pedestrian/bicyclist struck by vehicle</b> — Includes collisions involved non-motorized road users with motorized vehicles during the disaster period.</li> <li>▪ <b>Structural collapse</b> — Include but not limited to building or shelter collapse</li> <li>▪ <b>Fall</b> — includes but not limited to falls on same level from slipping or tripping; falls involving ice and snow; falls from trees, bed, stairs, roofs, ladders, etc.</li> <li>▪ <b>Cut/ struck by object/tool</b> — Includes but not limited to contact or collision with inanimate objects that results in a physical damage and causes death</li> <li>▪ <b>Poisoning/ toxin exposure</b> — Includes accidental poisoning by and exposure to liquids or gases and ingestion of drugs or substances.</li> <li>▪ <b>Suffocation</b> — Includes but not limited to mechanical or oxygen depleted environment</li> <li>▪ <b>Burn</b> - Includes but not limited to chemical, fire, hot object or substances contact</li> <li>▪ <b>Firearm/gunshot</b> — Firearm injuries, including self-inflicted</li> <li>▪ <b>Heat related injury</b> — Includes excessive heat as he cause of heat stroke, hyperthermia or others</li> <li>▪ <b>Cold related injury</b> — Includes excessive cold as the cause of hypothermia</li> </ul> <p><b>Q23 Cause of death/ illness</b> — Record the cause that best describes the disease process. If other, please specify.</p> <ul style="list-style-type: none"> <li>▪ <b>Neurological disorders</b> — Includes but not limited to CNS infectious disease, seizure disorder, intracerebral hemorrhage, cerebral infarction and stroke</li> <li>▪ <b>Respiratory failure</b> — Includes but not limited to COPD, pneumonia, asthma and pulmonary embolism</li> <li>▪ <b>Cardiovascular failure</b> — Includes but not limited atherosclerotic cardiovascular disease, heart failure</li> <li>▪ <b>Renal failure</b> — Includes kidney failure and other disorders of the renal system</li> <li>▪ <b>GI and endocrine</b> — Includes but not limited to upper and lower GI bleeding, jaundice, hepatoma and pancreas</li> <li>▪ <b>Sepsis</b> — Includes systemic infection</li> <li>▪ <b>Dehydration</b> — Include sensible and insensible fluid and electrolyte loses</li> <li>▪ <b>Allergic reaction</b> — Topical or systemic reaction including anaphylactic shock</li> </ul> <p><b>Q24. Cause of death:</b></p> <ul style="list-style-type: none"> <li>▪ <b>Confirmed</b> — If the cause of death was certain and confirmed by a ME/physician</li> <li>▪ <b>Probable</b> — If there is uncertainty to confirm the case</li> <li>▪ <b>Pending</b> — If the case is subject for further investigation</li> </ul> <p><b>Q25. Relationship</b></p> <ul style="list-style-type: none"> <li>▪ <b>Direct</b> — refers to a death caused by the environmental force of the disaster (e.g., wind, rain, floods, or earthquakes) or by the direct consequences of these forces (e.g., structural collapse, flying debris).</li> <li>▪ <b>Indirect</b> — refers to unsafe or unhealthy conditions, or conditions that cause a loss or disruption of usual services that contributed to the death. Unsafe or unhealthy conditions may include but are not limited to hazardous road conditions, contaminated water supplies, scattered debris. Disruptions of usual services may include but are not limited to utilities, transportation, environmental protection, medical care or police/fire.</li> <li>▪ <b>Possible</b> — refers to a death that occurred in the disaster-affected area during the disaster period. The cause or manner of death is undetermined or pending and the informant believes that a possible relationship between the death and the disaster might exist.</li> <li>▪ <b>Unrelated</b> — refers to a death with no relationship to the disaster</li> </ul> <p><b>Q26. Circumstance of death</b> — Text description of the death and preceding incidents</p> <p><b>Q27. Manner/intent of death</b> — Record the category that best describes the manner/intent of death</p> <p><b>Q28. Who signed</b> — Record the title that describes the person who signed the death certificate</p> <p><b>Q29. Date of report completed</b> — Date of the survey form completed in MM/DD/YY format</p>